

EXHIBIT 14

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK

MATTHEW RAYMOND, Plaintiff,

- V S -

18-CV-01467

TROY MITCHELL, LIEUTENANT AT AUBURN
CORRECTIONAL FACILITY; CHARLES THOMAS,
CORRECTION OFFICER AT AUBURN CORRECTIONAL
FACILITY; THOMAS HARTE, SERGEANT AT AUBURN
CORRECTIONAL FACILITY; THOMAS PHILLIPS,
CORRECTION OFFICER AT AUBURN CORRECTIONAL
FACILITY; THOMAS GIANCOLA, CORRECTION OFFICER
AT AUBURN CORRECTIONAL FACILITY; HAROLD D.
GRAHAM, FORMER SUPERINTENDANT OF AUBURN
CORRECTIONAL FACILITY; BRIAN BAUERSFELD,
CORRECTIONAL HEARING OFFICER OF AUBURN
CORRECTIONAL FACILITY; BRIAN O'HORA,
CORRECTION OFFICER AT AUBURN CORRECTIONAL
FACILITY; AIMEE HOPPINS, R.N.; DR. DEBORAH
GEER; AND "JOHN DOE", CORRECTION OFFICER AT
AUBURN CORRECTIONAL FACILITY,
Defendants.

REMOTE EXAMINATION BEFORE TRIAL OF

JONATHAN M. VAPNEK, MD

Friday, March 11, 2022

2:01 p.m. - 3:54 p.m.

pursuant to notice

REPORTED BY:

Carrie A. Fisher, Notary Public

APPEARING REMOTELY FROM ERIE COUNTY, NEW YORK

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1 **R E M O T E A P P E A R A N C E S**

2 APPEARING FOR THE PLAINTIFF:

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15 ALSO PRESENT (OBSERVING):

16 **BONNIE LEVY, ESQ.**
17 NYS Attorney General's Office

18 **EMMA FREEMAN, ESQ.**
19 Emery Celli Brinckerhoff Abady Ward
20 & Maazel LLP

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1 REPORTED REMOTELY FROM ERIE COUNTY, NEW YORK

2 THE REPORTER: Good morning. My name is
3 Carrie Fisher. I am the stenographic court
4 reporter. I am not physically present with
5 the witness and will be reporting this
6 deposition remotely.

7 Will the attorneys participating in this
8 deposition acknowledge that, in lieu of an
9 oath administered in person, I will administer
10 the oath remotely and further consent to waive
11 any objections to this manner of reporting.

12 Please indicate your agreement by
13 stating your name, who you represent and your
14 agreement on the record, starting with the
15 noticing attorney.

16 MR. MACKEY: Patrick Mackey on behalf of
17 the defendants Mitchell, Thomas, Harte,
18 Phillips, Giancola, Graham, and Geer, and I
19 consent.

20 MS. ROSENFIELD: Katie Rosenfeld for
21 plaintiff, I consent.

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JONATHAN VAPNEK, MD - BY MR. MACKEY - 03/11/22

1 J O N A T H A N M. V A P N E K, M D,
2 229 East 79th Street, New York, New York
3 10075, having been first duly sworn, was
4 examined and testified as follows:

5
6 EXAMINATION BY MR. MACKEY:

7 Q. Good afternoon, Dr. Vapnek. My name is
8 Patrick Mackey. I am one of the attorneys
9 representing the defendants in this case.
10 Thank you for your time and thanks for
11 appearing today for this particular
12 deposition.

13 I will have a series of questions for
14 you, and before we get started though I just
15 want to kind of lay some ground rules so it
16 goes as smoothly as possible. One is just
17 kind of wait until I finish my question before
18 jumping in with your answer. If we start
19 talking over each other, it's difficult for
20 the stenographer so if you could just wait
21 until I am done with my question. And I will
22 do the same, I will wait until you're done
23 with your answer before I go on to my next

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1 question.

2 We do need verbal answers. A shake or a
3 nod of the head isn't recordable so everything
4 needs to be verbal.

5 Just let me know if you don't understand
6 a question. I'd like you to be answering
7 questions you understand. If there is a
8 question you're just not quite understanding
9 what I am asking you, that's fine, just let me
10 know. I will ask it a different way or maybe
11 break it down into smaller questions.

12 There may be objections by the attorney,
13 your attorney, during the deposition which is
14 normal. I just ask that you answer the
15 question once the objection has been placed on
16 the record.

17 And if you do need a break at any time,
18 just let me know. It's no problems taking a
19 short break for whatever reason you may need
20 it. The only thing I ask is if there is a
21 question pending that the question be answered
22 before we take that break. All right?

23 A. All right.

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1 Q. Okay. So let's get started.

2 Dr. Vapnek, are you licensed to practice
3 law in the state of New York?

4 A. I am licensed to practice medicine but not law
5 yet.

6 Q. Did I say law?

7 A. You did.

8 Q. Are you licensed to practice medicine in the
9 state of New York?

10 A. I am.

11 Q. Okay. When did you obtain that license?

12 A. 1993 when I moved to New York.

13 Q. Okay. Where did you move from?

14 A. California.

15 Q. Were you practicing medicine in California
16 when you moved to New York?

17 A. No, I had done my residency and my fellowship
18 there and I keep my license current just in
19 case.

20 Q. Okay. Are you practice -- currently are you
21 licensed to practice medicine in California?

22 A. I am.

23 Q. Okay. Any other states that you're licensed

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1 to practice medicine?

2 A. No.

3 Q. Okay. So just New York and California?

4 A. Correct.

5 Q. Okay. Do you have any board certifications?

6 A. I do.

7 Q. And what are those in?

8 A. American Board of Urology. My initial
9 certification was 1995, and I have recertified
10 twice so I am good to go until 2025.

11 Q. And where are you currently employed?

12 A. I am self-employed in Manhattan.

13 Q. So you have your own practice?

14 A. I do.

15 Q. And what's the name of the practice?

16 A. Jonathan Vapnek, MD, PC.

17 Q. Before working at your own practice, did you
18 work elsewhere in the medical field?

19 A. I did. I was full-time staff at Mount Sinai
20 Medical Center from 1993 until November of
21 2002, at which point I decided to go out into
22 solo private practice.

23 Q. Okay. So Jonathan Vapnek, MD, PC, that began

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1 in 2002?

2 A. Correct.

3 Q. Have you ever provided medical services in a
4 correctional facility?

5 A. No.

6 Q. Okay. And do you did you review any documents
7 in preparation for today's deposition?

8 A. Yes.

9 Q. What documents did you review?

10 A. Well, I have obviously all the records that I
11 reviewed to formulate my December 15th letter.
12 I looked back at some of my notes,
13 occasionally looking at some of the source
14 material.

15 Q. Okay. Anything else? Did you review any
16 other reports prepared by experts related to
17 this case in preparation for this deposition?

18 A. Well, there were the plaintiff's expert
19 neurologist which is Sherry Leitch and then
20 the two defense experts John Valvo who is the
21 urologist and Robert Knapp who is the
22 neurologist.

23 Q. Okay. And you took a look at those before for

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1 today's deposition?

2 A. Yes.

3 Q. Okay. Anything else, any other documents that
4 you reviewed?

5 A. No.

6 Q. The plaintiff in this case, Matthew Raymond,
7 has he ever been a patient of yours?

8 A. No.

9 Q. Do you know if any members of Mr. Raymond's
10 family has ever -- have ever been a patient of
11 yours?

12 A. Not that I'm aware of.

13 Q. Okay. Before providing Mr. Raymond with
14 expert witness services in this case, did you
15 know Mr. Raymond?

16 A. No.

17 Q. Okay. And before providing Mr. Raymond with
18 expert witness services in this particular
19 lawsuit, did you know any members of
20 Mr. Raymond's family?

21 A. Not that I'm aware of, no.

22 Q. Other than this particular lawsuit, have you
23 been hired in the past to provide expert

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1 witness services in lawsuits?

2 A. Yes.

3 Q. Okay. Approximately how many times in the
4 past?

5 A. What -- I mean, in terms of number of cases I
6 have reviewed or number of times I have
7 testified?

8 Q. Okay. We can break it down.

9 Approximately how many times have you
10 testified at trial as an expert witness?

11 A. I think I have testified at trial about 65
12 times.

13 Q. Okay. And if you can approximate, how many
14 times have you been hired to provide expert
15 witness services in a lawsuit, so not
16 necessarily just provide trial testimony but
17 to review medical records, prepare expert
18 reports, things of that nature?

19 A. I should probably figure this out but it's --
20 I mean, over the last 20 years it's got to be,
21 you know, 600 to a thousand cases. I do a lot
22 of -- a lot of reviews that never come to
23 deposition, a lot of reviews that never go to

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1 trial so there is a lot of behind the scenes
2 stuff.

3 Q. Understood. When you -- during your history
4 of providing expert witness services in
5 lawsuits, is that always in the field of
6 urology?

7 A. Yes.

8 Q. And I think you mentioned it's been about 20
9 years that you have been providing expert
10 witness services. During that 20-year period,
11 have you provided expert witness services to
12 defendants in lawsuits?

13 A. Yeah, most of -- I would say probably 65 --
14 you know, two-thirds of my work is defense
15 work, primarily in the New York area, and then
16 there is plaintiffs work in malpractice cases
17 and then there are the damages cases or
18 workers' comp and such.

19 Q. Okay. So would you agree that you do provide
20 expert witness services both sometimes on
21 behalf of defendants and sometimes on behalf
22 of plaintiffs?

23 A. That's correct.

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1 Q. The law firm that hired you in this particular
2 case, Emery Celli Brinckerhoff Abady Ward &
3 Maazel, have they hired you in the past for
4 expert witness services?

5 A. No.

6 Q. Okay. So this is the first time?

7 A. Yes.

8 Q. And the name of the law firm I belong to and
9 it's based in Buffalo, New York, is Lipsitz
10 Green Scime Cambria. Do you know if you have
11 ever been hired by that firm to provide expert
12 witness services?

13 A. I don't believe so.

14 Q. Now, I think you mentioned a little earlier
15 before that there have been occasions that you
16 have provided deposition testimony as an
17 expert. Approximately how many times have you
18 done that?

19 A. I think it's in the neighborhood of 75 or 80.

20 Q. Okay. And have you authored any publications?

21 A. Yes.

22 Q. Okay. What was your most recent publication
23 that you authored?

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- 1 A. That's a good -- I'd have to go back and look
2 at my CV. I don't do a whole lot of writing
3 these days, but probably about four or five
4 years ago I think one of my former residents
5 and I published a book chapter but I'd have to
6 go back and look at the CV.
- 7 Q. Okay. You just don't recall the specifics,
8 what publication that was?
- 9 A. That's right.
- 10 Q. Okay. Approximately how many articles or
11 other publications have you issued?
- 12 A. I think it's probably 30 or 40.
- 13 Q. Do you know if any of those were related to
14 the topic of neurogenic bladder?
- 15 A. Since my subspecialty area of expertise is
16 neurourology and voiding dysfunction, a lot of
17 my presentations and a fair number of articles
18 are generally about bladder control.
- 19 Q. Okay. So you're familiar with --
- 20 A. I don't know what that was, but we're still
21 here.
- 22 Q. Okay. You hear me fine?
- 23 A. Yep.

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1 Q. Okay. Now you mentioned that -- strike that.

2 Now, in your private practice do you
3 have patients that suffer from neurogenic
4 bladder?

5 A. Yes.

6 Q. Okay. Now, are you able to provide an
7 approximate percentage of how many of your
8 patients suffer that particular condition?

9 A. I can't give you an exact number, but
10 certainly since that, again, is my
11 subspecialty area, while I do general urology
12 and see kidney stones and prostate cancer and
13 such, there is certainly a larger number of
14 those with bladder control problems of which
15 neurogenic bladder is certainly a large
16 portion of that. So it's certainly in the
17 neighborhood of, I mean, overall couple
18 hundred patients. You know, I may not see
19 them more than once a year but there is
20 plenty.

21 Q. Understood. Is it over 50 percent of your
22 patients are patients that suffer from bladder
23 issues?

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1 A. No.

2 Q. Okay. So it's under 50 percent you think?

3 A. Yes.

4 Q. Now you mentioned earlier you have appeared
5 approximately 65 times prior -- 65 times at a
6 trial as a witness. Were all of those
7 appearances as -- were you appearing as an
8 expert witness?

9 A. Yes.

10 Q. Okay. And have you ever been not qualified by
11 a court or a judge during a trial?

12 A. Not that I'm aware of, no.

13 Q. Do you have any felony convictions?

14 A. Not that I'm aware of.

15 Q. Do you have any misdemeanor convictions?

16 A. No.

17 Q. Have you ever been disciplined for your
18 actions taken as a medical doctor?

19 A. No.

20 Q. Have you ever been sued for malpractice?

21 A. Yes.

22 Q. Okay. How many times, do you know?

23 A. Five times.

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1 Q. And if you know, what were the results of
2 those five lawsuits?

3 A. I think one of them may still be pending. I
4 haven't heard anything for a couple of years.
5 It seems pretty silly, but I don't honestly
6 know. The other four were either dropped or
7 settled on the behalf of others, so no
8 judgments or settlements for myself.

9 Q. Okay. Well, that kind of goes along with my
10 next question. Do you know if any of those
11 five lawsuits of liability was ever found
12 against you?

13 A. Right. There were none.

14 Q. Okay. And all five of these malpractice
15 lawsuits, were these related to your services
16 in the field of urology?

17 A. Yes.

18 Q. And were all five of these in New York?

19 A. They were.

20 Q. Okay. Do you know if they were state court
21 matters or federal court matters?

22 A. I would presume they were state court as they
23 were, you know, New York City based.

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1 Q. Okay. And the one lawsuit that's still
2 pending, how old is that lawsuit do you know?
3 Do you remember when it was filed?

4 A. I mean, I got deposed probably three years ago
5 and I think there was a motion to dismiss it
6 but I have literally not heard anything. I
7 really don't know.

8 Q. Okay. Have you ever been charged with ethical
9 violations in the medical field?

10 A. No.

11 Q. Now, the lawsuit that we're discussing today
12 was brought by the plaintiff whose name is
13 Matthew Raymond. And, as you know, you
14 provided an expert report on Mr. Raymond's
15 behalf. Did you ever meet to examine
16 Mr. Raymond?

17 A. No.

18 Q. Have you ever had any discussions with
19 Mr. Raymond?

20 A. No.

21 Q. Have you ever had any discussions with any
22 members of his family?

23 A. No.

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—JONATHAN VAPNEK, MD - BY MR. MACKEY - 03/11/22—

1 Q. Is it accurate to say that the report you
2 prepared for Mr. Raymond was just based upon
3 your review of medical records related to the
4 care that had been provided to Mr. Raymond?

5 A. Sure.

6 Q. Now, during your review of records related --
7 or records in order to prepare your expert
8 report, did you notice at any time that
9 Mr. Raymond had been diagnosed as being or
10 having depression?

11 A. I don't recall specifically. I was
12 concentrating more on the urological matters.

13 Q. Okay. So you just don't remember?

14 A. Correct.

15 Q. Upon your review of the records, did you come
16 across information related to the fact that
17 Mr. Raymond back in 2012 suffered a head
18 injury when he was hit by a beam at a work
19 site?

20 A. Yes.

21 Q. Okay. So you saw that in the records?

22 A. Yes.

23 Q. And upon your review of the records, did you

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1 notice or did you see that in 2007 Mr. Raymond
2 injured his spine in a medical -- in a
3 motorcycle accident?

4 A. I think that was something I read about, but I
5 don't think -- I don't think records extended
6 that far back that I saw.

7 Q. Okay. Yeah, in a little bit I will go over
8 the records that you went through. In
9 preparing your report, your report, your
10 expert report, did you give any consideration
11 about the head injury that Mr. Raymond
12 suffered in 2012?

13 A. Sure.

14 MS. ROSENFELD: Objection to the form.

15 Q. Okay. And what type of consideration did you
16 give it?

17 A. I think that any time one is doing a review
18 and looking for causation one has to fairly
19 take into account all of the potential issues
20 that might impact.

21 Q. Okay. And do you feel at all that that
22 particular injury, the injury in 2012 from
23 the -- from being hit in the head with the

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1 beam, is that a factor at all in Mr. Raymond
2 having a neurogenic condition of a neurogenic
3 bladder?

4 MS. ROSENFIELD: Objection to the form.

5 A. I think that it is a pre-existing condition,
6 but there was no evidence of any voiding
7 dysfunction prior to the incident of September
8 14th of 2016. So it may have perhaps
9 predisposed him to a higher degree of injury
10 from subsequent head injuries. So in that way
11 I suppose it's relevant, but from what I can
12 tell there was no issue -- no urological issue
13 from that specifically.

14 Q. Okay. Just so I understand, is it your
15 contention then that the injury that was
16 suffered in 2012 may have -- may have created
17 or did create a pre-existing condition that
18 may have caused later on Mr. Raymond to suffer
19 this neurogenic bladder?

20 MS. ROSENFIELD: Objection. Misstates
21 testimony.

22 A. I think that what I meant to say, maybe not so
23 artfully, was that having one head injury may

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1 predispose one to be more susceptible to a
2 second head injury, but that's speaking as a
3 urologist as opposed to a neurologist.

4 Q. Okay. And the injury to the spine from the
5 motorcycle accident in 2007, did you take that
6 into consideration at all when preparing your
7 expert report?

8 A. Yes.

9 Q. Okay. And how did you -- what consideration
10 did you give it?

11 A. Again, knowing that that was a pre-existing
12 condition that had not for nine years caused
13 any demonstrable deficit in voiding function.

14 Q. Okay. And do you feel at all that that injury
15 to the spine, to any degree, has it caused a
16 neurogenic bladder that Mr. Raymond currently
17 suffers?

18 MS. ROSENFIELD: Objection to the form.

19 A. Yeah, highly unlikely.

20 Q. And why do you think it's unlikely?

21 A. Again, the imaging was unimpressive and for
22 that long number -- nearly a decade there were
23 no urological issues.

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—JONATHAN VAPNEK, MD - BY MR. MACKEY - 03/11/22—

1 Q. Now upon reading the records that were
2 provided to you, did you notice that there is
3 a record of Mr. Raymond suffering seizures?

4 A. Yes.

5 Q. And those seizures appear to have started
6 once -- when he was hit with the beam in the
7 head -- in the head with the beam in 2012,
8 correct?

9 MS. ROSENFELD: Objection.

10 A. Right.

11 Q. Now I know you're not a neurologist but, I
12 mean, what is your understanding of the causes
13 of the seizure?

14 A. I mean, when I -- I have seen patients with
15 seizures over the years and certainly a
16 traumatic brain injury is one reason and
17 idiopathic or birth trauma is another one. I
18 think from what I have seen in many cases
19 there is no visible evidence on imaging, but
20 there is evidence on EEG or clinically that
21 there is an injury.

22 Q. And what do you mean by "there is no visible
23 evidence"?

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—JONATHAN VAPNEK, MD - BY MR. MACKEY - 03/11/22—

1 A. CAT scans often are negative and MRIs are
2 negative. So we certainly see -- you know,
3 and I think that's true in all aspects of
4 medicine that imaging studies are helpful but
5 they are limited and very often are negative
6 even when someone does have clinical symptoms.

7 Q. Okay. So just so I understand, are you saying
8 that a person may suffer from some seizures
9 but there won't be any indications of that
10 condition if they -- if you took an MRI or a
11 CT scan of their brain?

12 A. Right. That's my understanding, yes.

13 Q. Now you mentioned that you have patients that
14 have seizures. Do any of your patients that
15 have seizures, do any of them have bladder
16 retention issues?

17 A. I have not seen any in my practice.

18 Q. Okay. Have you ever encountered any patients
19 or any -- well, let me strike that.

20 Have you ever come across a situation
21 where seizures have been ruled as a cause of a
22 neurogenic bladder?

23 MS. ROSENFIELD: Objection to the form.

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1 A. I have not.

2 Q. Have you read any publications or articles
3 about neurogenic bladder being caused by
4 long-standing seizures being suffered by a
5 person?

6 A. No, but I can say certainly those with extreme
7 head injuries or strokes or other major space
8 occupying lesions causing seizures, something
9 like that, would -- it would not be unexpected
10 to have bladder dysfunction in those
11 situations.

12 Q. Okay. Now what -- what physical injuries did
13 Mr. Raymond sustain which caused him to suffer
14 a neurogenic bladder?

15 A. My understanding is that after the incident he
16 had a series of bruises that were noted. The
17 imaging studies did not show any acute
18 fractures or bleeds, but from what I
19 understand there was evidence that there was
20 physical trauma.

21 Q. Okay. Are you referring to the physical
22 trauma of September 14th of 2016?

23 A. Yes.

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1 Q. Okay. So upon your review of the records that
2 were provided to you, have you ever come
3 across any information which provides that
4 Mr. Raymond injured his spine during that
5 alleged assault?

6 A. What I have found certainly, and depending on
7 who is writing the history and which hospital
8 one goes to, there certainly were plenty of
9 notes eluding to a spinal cord injury.
10 Whether that was completely accurate or
11 whether that was just interpretation by those
12 particular physicians, it certainly shows up
13 in the record on numerous occasions.

14 Q. Have you seen any imaging, MRI, x-ray, or CT
15 scan showing Mr. -- showing that Mr. Raymond
16 suffered a fractured spine?

17 A. No. And as I said earlier, there is certainly
18 plenty of those -- I mean, there are patients
19 out there who have a very incomplete spinal
20 cord injury where there is no evidence on
21 imaging.

22 Q. Okay. And what do you mean by "incomplete"?

23 A. Well, someone -- I mean, obviously these cases

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1 are obvious, you know, somebody is injured: a
2 car accident, they're wheelchair bound and
3 they have spinal fractures and they have a
4 spinal cord with a lot of hemorrhage and edema
5 and all the rest of it. That's sort of the
6 one where it's obvious. And then there's a
7 lot cases where there is -- it's much, much
8 more subtle and the imaging studies themselves
9 may not show obvious injury.

10 Q. Okay. Do you feel that that's the case with
11 Mr. Raymond, that he suffered injuries to his
12 spine but it just cannot be identified on any
13 type of imaging?

14 A. I don't think that's a major factor here, no.

15 Q. Okay. Have you -- upon your review of the
16 records, have you seen any imaging of his
17 brain which identifies the injury which caused
18 his neurogenic bladder?

19 A. No.

20 Q. And have you reviewed any type of imaging of
21 Mr. Raymond's neck which identifies an injury
22 which caused his neurogenic bladder?

23 A. No.

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1 Q. Have you viewed any type of imaging which
2 identifies the injury that caused
3 Mr. Raymond's neurogenic bladder?

4 A. No.

5 Q. And do you believe that Mr. Raymond suffers
6 from a neurogenic bladder?

7 A. Yes.

8 Q. Okay. What is your opinion of the injury that
9 has caused his neurogenic bladder?

10 A. I think most likely it is his traumatic brain
11 injury that led to the pelvic pain and
12 inability to urinate, and consequently the
13 need for indwelling catheter and then
14 eventually augmentation cystoplasty with
15 catheterizable channel. And, again, that's
16 not -- that's based on the fact that he really
17 had no urological complaints whatsoever before
18 the injury and after the injury he developed
19 marked voiding dysfunction associated with the
20 pelvic pain.

21 Q. Okay. What -- and you mentioned the traumatic
22 brain injury. What injury are you referring
23 to?

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1 A. So he has -- according to the neurologists, he
2 does have evidence of cognitive dysfunction
3 and other -- other problems related to his
4 brain function and those -- those issues are
5 most likely related and explain why he has
6 this other issue with inability to urinate on
7 his own.

8 Q. Okay. But when you refer to the injury, what
9 event are you referring to to cause that
10 injury?

11 A. Well, the September 14th of 2016.

12 Q. Now, the defendants in this case, the
13 corrections officers in this case, deny that
14 there was any physical assault of Mr. Raymond
15 on September 14th of 2016. If that was the
16 case, is there another explanation for
17 Mr. Raymond's neurogenic bladder?

18 MS. ROSENFELD: Objection to the form.

19 A. I mean, I don't -- from everything I have
20 read, it appears that there was an assault. I
21 suppose I guess somebody could assault him or
22 herself. I don't know how that would happen,
23 but some sort of trauma did occur and

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1 following that trauma he ended up with a
2 serious bladder problem.

3 Q. So it's possible that there could have been
4 other trauma to Mr. Raymond's brain other than
5 the alleged assault of 09/14/16 that caused
6 the neurogenic bladder?

7 MS. ROSENFIELD: Objection to the form.

8 A. I mean, again, that would be conjecture, but I
9 suppose something else could have happened
10 that we don't know about.

11 Q. Okay. When you were reviewing the records
12 that were provided to you, did you see that
13 the day before on September 13th of 2016 that
14 Mr. Raymond suffered a seizure in his cell and
15 because of the seizure suffered a fall?

16 A. Yes.

17 Q. Okay. Could that fall have been the cause of
18 the damage to his brain?

19 MS. ROSENFIELD: Objection to the form.

20 A. I don't -- I don't know enough about how much
21 of a fall there was. I don't -- from what I
22 saw in the records, it wasn't anything severe
23 at the time.

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1 Q. Okay. If that fall resulted in Mr. Raymond
2 hitting his head to the floor, could that have
3 caused a brain injury resulting in a
4 neurogenic bladder?

5 MS. ROSENFELD: Objection to the form.

6 A. I mean, hypothetically, it's certainly
7 possible.

8 Q. Did you review any of the records related to
9 the -- his visit to the hospital on September
10 13th because of that seizure and fall?

11 A. Yes.

12 Q. And did you notice that there was reference to
13 him -- to Mr. Raymond injuring his neck during
14 that fall?

15 A. I don't -- I don't recall the specific note,
16 but I believe that he was evaluated and was
17 sent back.

18 Q. And when you say "sent back," you mean back to
19 the correctional facility?

20 A. Right. I mean, they decided that there was --
21 that he didn't require hospital admission.

22 Q. I am going to be showing you some exhibits on
23 the screen for you to take a look at.

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1 Obviously I will do that one by one. The main
2 document I do want to review with you is your
3 report which I have marked as Exhibit 1, so
4 let me put that up on the screen for you.

5 Give me one moment, please.

6 Dr. Vapnek, do you see the document on
7 the screen?

8 A. Yes.

9 Q. Okay. And if you see at the bottom it's
10 marked as Exhibit 1. So this is your report
11 of December 15th, 2021, correct?

12 A. Yes.

13 Q. Okay. Now, on the first page which we are
14 looking at right now, it looks like that's a
15 list of the records you reviewed; is that
16 correct?

17 A. Yes.

18 Q. Okay. And did you review all of these records
19 in preparation of your report?

20 A. Yes.

21 Q. Now it looks like the earliest -- the earliest
22 record you looked at was outpatient records
23 from Upstate University Hospital starting

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1 January 19th, 2017. Do you see the portion
2 that I highlighted?

3 A. Yes.

4 Q. Okay. Of the records that you listed, that's
5 the earliest date. Do you know, did you
6 review any records that were dated prior to
7 January 19th of 2017?

8 A. I had -- I know I had seen that emergency room
9 visit, and I believe I had seen some earlier
10 records as well. I don't know, I might have
11 missed them in this bullet list.

12 Q. Okay. When you say emergency room records, do
13 you remember what time period that was?

14 A. I think that was at the -- I think that was
15 the September of 2016.

16 Q. Okay. So was that the emergency records
17 immediately after the alleged assault of
18 September 14th of 2016?

19 A. Right.

20 Q. Now -- I am sorry, go ahead.

21 A. No, I am saying it's possible it was embedded
22 in some of the other records. The records
23 were rather voluminous, so I wouldn't be

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1 surprised if they were contained within one of
2 the other ones and I forgot to tease it out.

3 Q. Okay. I understand. Now looking at this
4 list, I also don't see, or at least I don't
5 think I see, any records identified or you
6 identifying any records, medical records, from
7 Auburn Correctional Facility, any Department
8 of Corrections records. Do you know if you
9 did review records that were provided or
10 prepared by medical staff at the Auburn
11 Correctional Facility?

12 A. I do believe that I saw some of those as well.
13 It may not have been all of them and, again, I
14 don't know why it didn't make it into this
15 list.

16 Q. Okay. And if you recall, what was the time
17 period of those records, the records from
18 Auburn Correctional Facility?

19 A. You know, I just don't recall. I believe that
20 what I ended up seeing was late 2016 up
21 through the first visit to Upstate in January
22 of '17, so I think it was just that four-month
23 period from September of 2016.

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1 Q. Okay. So let's go through your report. I do
2 have some questions from the report that you
3 prepared.

4 Scrolling to the second page of your
5 report, right on the top you wrote that Mr. --
6 and I will just highlight these two sentences.
7 That Mr. Raymond was assaulted by a New York
8 State corrections officer on September 14th,
9 2016, and you wrote, "sustaining blows to his
10 neck, head, face, chest, and genital region
11 using closed fist and a baton." Did I read
12 that correctly?

13 A. Yes.

14 Q. Where did you get that information from to
15 include in your report?

16 A. I believe I got that from having read the
17 report of Dr. Leitch.

18 Q. Okay. And the next paragraph, I will
19 highlight that portion, you wrote, "shortly
20 after that incident, he developed difficulty
21 urinating." Where did you get that
22 information from?

23 A. So I believe that came from the corrections

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1 records.

2 Q. The medical records from the correctional
3 facility?

4 A. I believe so.

5 Q. Now later in that paragraph it mentions that
6 during Mr. Raymond's visit to Upstate
7 University Hospital on January 19th of 2017 he
8 received a Foley catheter. Do you see that?

9 A. Yes.

10 Q. Okay. Now, Foley catheter is a type of
11 catheter which is installed directly into the
12 urethra, correct?

13 A. Yes.

14 Q. Okay. Now, it mentions as soon as the
15 catheter was placed there was immediate relief
16 of pain. Is that common when a catheter is
17 inserted?

18 A. Yes.

19 Q. Okay. What is happening in the body that
20 there is an immediate relief of pain?

21 A. The bladder has receptors that sense pressure
22 generally. So a bladder that gets
23 overdistended is generally quite painful, and

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1 once the bladder is decompressed the pressure
2 is relieved and the pain improves.

3 Q. Okay. So the pain is somewhat related to the
4 actual fact that the bladder is at a very full
5 state?

6 A. Absolutely, yeah.

7 Q. Okay. Then the next paragraph makes reference
8 to five days later Mr. Raymond was seen by
9 Urologist Timothy Byler, MD, at Upstate
10 University Hospital. Are you referring to
11 five days after January 19th of 2017?

12 A. Yes.

13 Q. And later on in that paragraph, and I will
14 highlight it, "Dr. Byler felt that
15 Mr. Raymond's difficulty urinating was likely
16 secondary to a traumatic urethral stricture."
17 Do you see that?

18 A. Yes.

19 Q. So how would you -- how would you describe a
20 urethral stricture?

21 A. Urethral stricture is scar tissue that forms
22 in the urethra, either from trauma or from an
23 infection, and is certainly one of the causes

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1 of urinary retention.

2 Q. Okay. Now, eventually upon reviewing records
3 from later dates it was determined that
4 Mr. Raymond did not or was not suffering a
5 urethral stricture, correct?

6 A. Right.

7 Q. Okay. So Dr. Byler's, I guess, feeling at
8 that point that it could be a traumatic
9 urethral stricture, it ended up being
10 disproven, correct?

11 A. Right.

12 Q. Okay. Now, at that point the record that was
13 prepared on that date, which was five days
14 after January 19th of 2017, to your
15 recollection or if you have the documents in
16 front of you, was there any reference to
17 Mr. Raymond possibly suffering a neurogenic
18 bladder?

19 A. I don't remember whether he established a full
20 differential diagnosis or whether he just went
21 with his number one possibility, but that's --
22 we can certainly go back and look at the
23 original documents, but I think his

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1 interpretation at the time was certainly a
2 reasonable -- you know, was a reasonable
3 diagnosis based on what he knew at the time.

4 Q. Okay. So at that time it appears that
5 Dr. Byler was feeling that Mr. Raymond was
6 suffering a stricture rather than a neurogenic
7 bladder, correct?

8 MS. ROSENFIELD: Objection.

9 A. That's right.

10 Q. I am sorry, what was your answer?

11 A. Yeah, that's what his -- again, that was his
12 number one choice of potential diagnoses.

13 Q. Okay. The next paragraph, and I will just
14 highlight this portion, references that on
15 March 7th, 2017, Mr. Raymond underwent a
16 cystoscopy and a voiding -- and I don't know
17 if I am going to say this word correctly --
18 cystourethrogram.

19 A. 90 percent.

20 Q. I am sorry?

21 A. You get 90 percent right.

22 Q. Thank you.

23 Let's take those individually. What

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1 exactly is a cystoscopy?

2 A. So a cystoscopy is putting a scope through the
3 urethra into the bladder looking for any
4 abnormalities of the lining of the bladder and
5 the lining of the urethra, and the voiding
6 cystourethrogram is an x-ray study in which
7 one puts contrast material into the bladder,
8 again, to look at the configuration of the
9 bladder. And both of those tests were done
10 sort of sequentially and showed that there was
11 no evidence of a stricture.

12 Q. Okay. So it looked like as of March 7th of
13 2017, upon those two tests being done on
14 Mr. Raymond, there was a determination that
15 there was no -- he was not suffering a
16 urethral stricture; is that correct?

17 A. That's right.

18 Q. So roughly speaking, it took about two months
19 from the time Mr. Raymond was brought to the
20 hospital in January and then until March of
21 2017 to make -- to rule out a possible
22 stricture, correct?

23 A. Fair enough, yes.

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1 Q. Now, if Mr. Raymond was suffering a neurogenic
2 bladder instead of a urethral stricture at
3 that time, would that two-month delay cause
4 problems or cause his neurogenic bladder to
5 worsen?

6 A. No.

7 Q. Okay. So once he had the neurogenic bladder,
8 is it fair to say it couldn't get worse?

9 A. I think, you know, sometimes the behavior of
10 neurogenic bladders is difficult to predict,
11 but having sort of missed the diagnosis on the
12 first round and establishing it in the second
13 round I don't think was -- I don't think that
14 really made a difference one way or the other.

15 Q. So if the alleged assault happened in
16 September of 2016 and he didn't visit the
17 hospital, the Upstate University Hospital
18 until January 19th of 2016 -- or '17, excuse
19 me, so roughly a four-month period, would that
20 four-month period cause any type of
21 possibility of his neurogenic bladder
22 worsening?

23 A. In this case, no. If somebody were in florid

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1 retention with a markedly distended bladder,
2 you know, like two liters of urine for a month
3 or two I think that would be different. But
4 when he eventually went in and was
5 catheterized at 600 CCs, that's really not --
6 I mean, it's obviously a very, very full
7 bladder but it's not enough to cause any
8 permanent damage.

9 Q. So would you agree then that from the time the
10 belief that the neurogenic bladder started in
11 September of 2016 to March of 2017 his
12 neurogenic bladder condition did not worsen at
13 all?

14 A. I -- again, it's -- you know, it's always hard
15 to tell because we don't have objective data
16 during those four months. For example, we
17 don't have post-void residual urine
18 determinations by sonography or attempted
19 catheterizations, but I would say it's
20 unlikely that there was a substantial change
21 over four months. There was -- I mean, there
22 was a problem there. It became more
23 clinically apparent at that January visit.

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1 Q. Okay. And when someone is diagnosed with a
2 neurogenic bladder, is it safe to say it's
3 irreversible?

4 A. No. I would say that depending upon the
5 underlying cause, I think neurogenic bladders
6 can vary over time. So, for example, somebody
7 who has Parkinson's disease or multiple
8 sclerosis you may see a waxing and waning of
9 their symptoms. Somebody, on the other hand,
10 who has a complete spinal cord injury is not
11 likely to have any major change over time.

12 Q. How about with respect to this case where the
13 claim is that it's an injury to the brain
14 that's causing Mr. Raymond's neurogenic
15 bladder, would that be reversible at all?

16 A. You know, it's really hard to say because now
17 that he has undergone major reconstructive
18 surgery and has an augmented bladder with a
19 catheterizable stoma it's kind of impossible
20 to know what the underlying bladder function
21 is like. If -- you know, he did have an
22 indwelling catheter for a very long time and
23 he had the opportunity to void on multiple

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occasions with voiding trials but really was
unable to -- was unable to urinate on multiple
occasions so at least during those several
years there didn't seem to be a change.

5 Q. Okay. I guess I am more -- I am looking more
6 at an isolated time immediately after the
7 alleged assault. If he was indeed truly
8 assaulted on September 14th of 2016 and that
9 assault injured his brain causing a neurogenic
10 bladder, is there anything that could have
11 been done immediately after that incident to
12 stop the neurogenic bladder from developing?

13 A. I don't believe so, no.

14 Q. I am going to scroll down. We're still on
15 your expert report which is Exhibit 1. I am
16 going to look for the portion I am interested
17 in if you give me one moment.

23 A. Yes.

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1 Q. Okay. From where did you get that information
2 that he did not have a prior urological
3 history?

4 A. Based on the records that I reviewed including
5 some of the earlier records and the later
6 records there was no evidence that he had any
7 significant degree of voiding dysfunction
8 prior to September of 2016.

9 Q. I am going to scroll down just briefly to
10 Exhibit 2 which is the Department of
11 Corrections record from the infirmary, and
12 there is an entry from January 1st of 2016 so
13 we are talking about nine months before the
14 alleged assault. And there is a reference
15 to -- and, again, this is just to clarify this
16 does refer to Matthew Raymond, there is an
17 entry of a straight cath due to inability to
18 void. Do you see that?

19 A. Yes.

20 Q. Okay. Is it your understanding that that
21 entry is referring to the use of a catheter
22 because Mr. Raymond was unable to void his
23 bladder?

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1 A. It is -- I mean, it's an order. Looks like
2 it, what is that 8:10 AM, is that what it
3 says? It says "may straight cath due to the
4 inability to void." So I don't recall if he
5 required straight cath that one time. I don't
6 remember -- I just don't recall exactly what
7 this incident of December 31st of '15 and
8 January 1st of '16, I don't recall what had
9 happened here.

10 Q. Okay. But looking at this particular record,
11 there does appear to be some reference to
12 Mr. Raymond complaining on January 1st of 2016
13 of being unable to void his bladder, correct?

14 A. Right. Yeah, I am actually looking at the
15 second page of the exhibit, it looks like he
16 had just had a laparoscopic appendectomy; is
17 that right?

18 Q. Are you looking at this page that I have on
19 the screen?

20 A. Yes.

21 Q. Okay. Let me know when you're done reading.

22 A. Yeah, no, I am just looking at it. It looks
23 like they were about ready to catheterize him.

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1 So I suspect, and I don't recall if I had seen
2 this before, that after surgery and having
3 been anesthetized it's not uncommon to have a
4 very brief period of difficulty urinating.

5 Q. And you made a reference to an appendectomy
6 which Mr. Raymond's on record of claiming
7 having been done. In your experience, have
8 you ever seen the procedure of an appendectomy
9 causing someone to suffer neurogenic bladder
10 at a later time?

11 A. No. No. I think it's very common for post-op
12 after surgery to have a very short period of
13 time, you know, usually 24 hours of difficulty
14 urinating because of the effect of the
15 anesthesia in decreasing bladder function, but
16 that's generally gone within 24 hours.

17 Q. Okay. I am going to go back up to your
18 report, back to page 3. Now, I will highlight
19 it for you.

20 There is a comment of Mr. Raymond had a
21 urodynamic study in November of 2017 which was
22 abnormal. What exactly is a urodynamic study?

23 A. Urodynamics or a urodynamic study involves

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1 placing a catheter in the bladder, often with
2 another catheter in the rectum, primarily to
3 measure bladder pressure and function during
4 filling and voiding, and it's considered the
5 best test, albeit limited, of bladder function
6 that we have.

7 Q. Okay. What was the purpose of doing that
8 study on Mr. Raymond at that time?

9 A. The idea of during urodynamics is to try and
10 get some insight into why -- why he was unable
11 to urinate. And several different outcomes
12 can be seen from a urodynamic study. One is,
13 as in this case, the bladder just doesn't
14 contract which we would call acontractility or
15 areflexia. Another possibility would be that
16 there is a physical blockage, for example, in
17 an older guy from prostate enlargement or from
18 sphincter non-relaxation. So urodynamics is
19 indicated to get an idea of what -- you know,
20 try and explain why someone can't urinate in
21 this particular case.

22 Q. Okay. So this study was done after it was
23 determined that it was not a urethral

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1 stricture, correct?

2 A. That's exactly right.

3 Q. So at this time is it fair to say the study
4 was done just in an attempt to identify the
5 reason Mr. Raymond was suffering a neurogenic
6 bladder?

7 A. Exactly.

8 Q. Okay. And you wrote that the study came back
9 abnormal. Why did you write that?

10 A. Right. So a normal urodynamic study would
11 involve noting when there was a first
12 sensation, a first feeling of fullness, and
13 then strong sensation of fullness and then in
14 a normal urodynamic study, one would then
15 generate a bladder contraction which would
16 empty the bladder. Bladder pressures of a
17 certain degree, you know, you don't want them
18 too high or too low, but the idea would be
19 that you would have normal sensation, normal
20 contractility, and at the end of it you would
21 have a bladder that was essentially empty.

22 And what made this urodynamic study
23 abnormal is that the bladder didn't do

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1 anything. He felt the sensation of fullness
2 relatively early, I think it was 200 and
3 something CCs, I'd have to look and see if I
4 can find it there, but it was a relatively low
5 volume but despite the fact that he had a
6 strong urge to go, nothing happened and then
7 they had to unclamp the suprapubic tube and
8 terminate the study.

9 Q. So would it be fair to say that that study
10 confirmed -- well, strike that.

11 Later on in that paragraph in your
12 report you wrote, "while it is helpful to have
13 abnormal imaging or an abnormal neurological
14 examination to bolster the diagnosis of
15 neurogenic bladder, there is no requirement
16 for such evidence." Did I read that
17 correctly?

18 A. Yes.

19 Q. Okay. Now, is that a reference to what we
20 were talking about earlier that there is no
21 imaging identifying the actual injury that
22 caused the neurogenic bladder?

23 A. Exactly.

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1 Q. Okay. Why do you write that there is no
2 requirements for such evidence?

3 A. The reason I write that is that there are just
4 plenty of cases we see clinically where
5 somebody has a very real bladder dysfunction
6 but imaging studies are not informative.
7 Again, it's great if you can identify
8 something on an imaging study. You know, we
9 will certainly do that.

10 If somebody walks into the office with
11 no good history, we may get a -- for example,
12 an MRI of the lumbar spine to look for any
13 evidence of a nerve problem in the lower
14 spine. Once in a while we find something.
15 Most of the time -- or I shouldn't say most
16 but many times we don't. But meanwhile the
17 patient does have a significant degree of
18 bladder dysfunction but the imaging study just
19 doesn't help us, that's all.

20 Q. In all instances where a person has a
21 functioning bladder but there is no imaging
22 to confirm the cause of that dysfunctioning
23 bladder, is that neurogenic bladder always

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1 caused by physical trauma to the person?

2 MS. ROSENFIELD: Objection to the form.

3 Go ahead. You can answer.

4 A. No, not necessarily. Like I said, it could be
5 all sorts of other possibilities. I don't
6 think they're relevant in this case but
7 certainly.

8 Q. What other possible reasons could someone
9 suffer a neurogenic bladder without imaging
10 proving the cause of the dysfunction --
11 dysfunctioning bladder?

12 A. I mean, I will say as an example, somebody
13 could be taking certain medications that
14 affect bladder function, and tend to paralyze
15 the bladder, that -- that would be one
16 possibility. One could envision other
17 scenarios where bladder function is abnormal
18 that are nontraumatic.

19 Q. Okay. Could it be caused by someone who has
20 repeated use of illicit drugs?

21 MS. ROSENFIELD: Objection.

22 A. I have never -- I mean, I think if somebody
23 acutely -- if somebody is taking, you know,

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1 for example, a large amount of narcotics on a
2 regular basis, one acutely can have some
3 effect on bladder function but that's not
4 something expected to last. And certainly
5 once -- you know, patients who are taking, for
6 example, Percocets or methadone long term we
7 generally do not see bladder dysfunction like
8 this with the possible exception of ketamine.

9 Q. What is that?

10 A. Ketamine is a -- I think it's like a horse
11 tranquilizer or something that has -- that has
12 been seen on occasion to cause some strange
13 bladder dysfunction. It's very rare.

14 Q. Okay.

15 A. But in general, you know, somebody who smokes
16 dope or somebody who does, you know, crack
17 cocaine, I mean, we may see somebody with an
18 acute issue when they're intoxicated, for
19 example, in an emergency. But once the acute
20 intoxication is gone, bladder returns to
21 normal. It certainly wouldn't cause any sort
22 of long-term issue.

23 Q. Now in his records, and I don't know if you

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1 saw this or not, Mr. Raymond has admitted on
2 several times to smoking marijuana, taking
3 cocaine, taking heroin. Is it possible that
4 his use of drugs, of those particular drugs,
5 created the condition he has right now of the
6 neurogenic bladder?

7 MS. ROSENFELD: Objection to the form.

8 A. Extremely unlikely. As I said, I mean, again
9 people who are acutely intoxicated, I mean,
10 even alcohol even more probably commonly than
11 other, you know, quote-unquote illegal drugs
12 or illicit drugs but they all -- we certainly
13 see those periodically in the acute situation
14 but not chronically, not to the point that
15 somebody would end up undergoing a four-hour
16 reconstructive surgery for a bladder that
17 doesn't work.

18 Q. Okay. Have you ever read any type of articles
19 or papers regarding individuals who suffered a
20 permanent neurogenic bladder because of use of
21 illicit drugs?

22 A. I have not.

23 Q. I want to scroll down a little further on

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1 page -- to the bottom of page 3 of your
2 report. I highlighted a sentence near the
3 bottom. There is a reference in that sentence
4 to brain lesion. Do you see that?

5 A. Yes.

6 Q. What do you mean by brain lesion?

7 A. So, again, this would be the more obvious
8 central nervous system problem like a bleed in
9 the brain or a brain tumor or multiple
10 sclerosis where there is evidence of plaque in
11 the brain. When one has what we call a
12 supratentorial lesion like that, the classic
13 textbook says that you're going to have an
14 overactive bladder with urgency frequency and
15 urge incontinence. That's what the classic
16 textbook says that that's what you get with
17 a -- you know, something that's demonstrable
18 like that.

19 Q. Could a brain lesion lead to the inability to
20 void your bladder?

21 A. Sure.

22 Q. Could a brain lesion lead to an individual
23 developing a neurogenic bladder condition?

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1 A. Yes.

2 Q. Now, does it have to be any particular type of
3 lesion or it could be any type of lesion?

4 A. No, again, you know, when you can see things
5 on MRIs or CAT scans, that's great but, you
6 know, the brain is a pretty subtle organ and
7 there is lot of, you know, what is it,
8 trillions of connections with neurons and
9 synapses and all the rest of it.

10 You know, for example, the current
11 thinking is that the coordination of voiding
12 is something that occurs at the level of the
13 pons and so anything above the pons is going
14 to give you that hyperreflexic situation, and
15 something below the pons can give you
16 something called dyssynergia. But at least in
17 theory if some lesion were to effect the area
18 around the pons, that would potentially cause
19 urinary retention because of the lack of
20 coordination there.

21 So, again, brains are, you know, very --
22 it's very difficult to predict unless it's
23 something very obvious. Like I said, like a

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1 tumor that's in one particular spot, you can
2 pretty much guess what that's going to do
3 based on where it is.

4 Q. Now a lesion that causes neurogenic bladder,
5 does it have to be on the pons or located near
6 the pons?

7 A. Absolutely not. Like I said, it could be
8 anywhere, you know, anything above the pons,
9 at the pons, below the pons. I mean,
10 neurogenic bladder is a pretty broad term so
11 it really is very, very broad and frankly
12 nonspecific.

13 Q. Okay. So let me do this, let me scroll to
14 Exhibit 3 of your deposition. This is a
15 document from the Auburn Community Hospital
16 Imaging Department. Do you recall if you
17 reviewed this particular record when you
18 prepared your report?

19 A. Honestly, it looks familiar but I can't say
20 with any degree of certainty.

21 Q. Okay. So according to this record, there is a
22 CT scan of Mr. Raymond's brain which I am
23 highlighting the portion now which makes

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1 reference to a small isodense lesion. Do you
2 see that?

3 A. Yes.

4 Q. Okay. So that's referencing a lesion that was
5 found on Mr. Raymond's brain, correct?

6 A. Yes.

7 Q. Okay. Now with a lesion like that, is it
8 possible that that kind of a lesion could
9 cause a neurogenic bladder?

10 MS. ROSENFELD: Objection to the form.

11 A. I mean, I am not -- unfortunately, I am not a
12 radiologist. I am looking at this. It looks
13 like it says it's within the frontal bone just
14 superior to the ethmoidal air sinuses. So
15 this looks like some sort of cystic thing in
16 the bone itself, so I would say that's highly
17 unlikely to be related to brain function at
18 all.

19 Q. What do you mean by "cystic"?

20 A. What's that?

21 Q. What do you mean by "cystic"?

22 A. Well, it says -- well, you know what, did I
23 say cystic? I don't know why that -- I am

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1 looking at this, just looking -- I am reading
2 it. It just says isodense well-circumscribed
3 with a sclerotic border. Anyway, it looks to
4 me like they're describing something in the
5 bone as opposed to in the brain. So I think I
6 don't know why -- if I said cystic, I misspoke
7 but it looks like it's a benign bone lesion as
8 opposed to a brain lesion.

9 Q. Okay.

10 A. Which is why at the bottom it says "no acute
11 intercranial abnormality identified."

12 Q. Okay. So is it your opinion that because of
13 the location of this particular lesion that
14 it's unlikely to have caused Mr. Raymond's
15 neurogenic bladder?

16 A. Correct.

17 MS. ROSENFIELD: Objection.

18 A. Oh, and by the way, actually I may have -- I
19 don't know where cystic came from but if you
20 scroll to the next page, I almost anticipated
21 this I guess where he says "the lesion in the
22 right anterior frontal bone has benign
23 appearances and may represent a dermoid or

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1 epidermoid cyst."

2 Q. Okay. What exactly is a dermoid or epidermoid
3 cyst?

4 A. It's benign, that's what it is, but I would
5 defer to a neuroradiologist.

6 Q. Okay. Let's go back to your report.

7 Let's go to -- okay, yeah, we're on page
8 4. At one point you wrote "a more subtle
9 injury could certainly become clinically
10 apparent over a longer period of time." Do
11 you see that portion?

12 A. Yes.

13 Q. And what --

14 MS. ROSENFIELD: Sorry, I am just trying
15 to find it on my copy. One second.

16 MR. MACKEY: Okay.

17 MS. ROSENFIELD: Okay. Go ahead. Sorry,
18 Counselor.

19 MR. MACKEY: I do have it highlighted on
20 the screen if you look at that.

21 MS. ROSENFIELD: For some reason I can't
22 see it on the screen. My eyes are not good so
23 I am just looking at the copy you sent me.

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1 MR. MACKEY: Okay. So did you find it?

2 MS. ROSENFELD: Mhmm.

3 BY MR. MACKEY:

4 Q. What did you mean when you wrote that?

5 A. Meaning that when we see patients with voiding
6 problems they may be able to compensate at
7 first. I mean, other than his seizure and his
8 prior brain injury, he is a relatively healthy
9 guy. He is a young guy, doesn't have a big
10 prostate. So if he were to have a problem
11 urinating, it wouldn't be all or nothing. You
12 know, if this were a 65-year-old guy, he might
13 have developed retention immediately just
14 because the effect on his bladder function
15 would have been much more obvious in the
16 presence of a pre-existing prostate problem.

17 I don't know if that's a good example
18 but, you know, somebody like this could have a
19 problem which just wasn't really clinically
20 apparent. It might have manifested as some
21 urgency, some frequency, some symptom that
22 just ended up he could compensate for it until
23 he couldn't compensate for it. And then at

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1 four months he ends up going in with obvious
2 retention. So it may have been if we had done
3 a sonogram at six weeks out we would have seen
4 that his bladder was not emptying and that
5 there was already a problem. It just wasn't
6 clinically apparent to him at that point.

7 Q. Okay. So could that explain why there may
8 have been a four-month period between
9 September 14th, 2016, date of the alleged
10 assault and Mr. Raymond's first visit to
11 Upstate University Hospital in January of
12 2017?

13 MS. ROSENFIELD: Objection to the form.

14 A. Yeah, I mean, I think that's a reasonable -- I
15 mean, it could be -- I mean, I don't know what
16 the politics are in terms of going to the
17 infirmary and when they -- you know, when they
18 send you back to your cell versus when they
19 decide to send you off to an emergency room
20 so, you know, that certainly goes into it.

21 It could also have been that he was
22 not -- like I said, that he wasn't even aware
23 of it as much but once his bladder got

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1 decompressed in January of 2017 then sort of
2 the die was cast as it were, and at that point
3 once they tried to, you know, clamp the
4 catheter or take it out, he failed voiding
5 trials so we certainly see that.

6 I think this would be a terrible analogy
7 but somebody who has lung cancer and they say,
8 oh my God, you have two months to live, you
9 know, you know the lung cancer didn't just
10 show up. It was there for six months earlier.
11 It's just that somebody was unaware of it. So
12 I think that's something that we see in
13 voiding dysfunction is that things can be --
14 it's not all or none.

15 Q. Okay. So just so I understand what you're
16 saying, in this case, Mr. Raymond is claiming
17 that strikes to his head -- blows to his head
18 and neck and face resulted in injury that
19 caused a neurogenic bladder. Are you saying
20 that even though they -- those particular
21 strikes to the head may have caused neurogenic
22 bladder the actual symptoms may not have
23 occurred until later on?

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1 A. Well, correct, that the full fledged symptom
2 of inability to urinate may not have been
3 present from the get-go, like on the day of,
4 and so that is exactly what I am saying.

5 Q. Okay. Isn't it common though if someone
6 injures their head, their brain, their neck or
7 their spine for them to have a rather
8 immediate -- let me rephrase that.

9 Is it common for individuals who suffer
10 a fractured spine or a fracture in their neck
11 or a severe head trauma to suffer neurogenic
12 bladder soon after the actual event?

13 A. I would agree with that. I would say
14 something that's, you know, again, much more
15 obvious, like a full spinal cord injury or
16 cracked skull with a big brain bleed, yes,
17 that's something where you're more likely to
18 see something that's -- you know, that is
19 clinically apparent earlier as opposed to a
20 delay but this is obviously a much more subtle
21 type of injury.

22 Q. So is it fair to say that the delay we're
23 seeing here is kind of a rare occurrence?

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1 MS. ROSENFIELD: Objection to the form.

2 A. I wouldn't -- what I would say is that it
3 certainly is consistent with an injury that is
4 not as clinically obvious. You know, it's --
5 it makes life a lot easier when you have got
6 something obvious like on an imaging study.
7 You know, a broken bone is something that's
8 very obvious or a subdural hematoma or an
9 epidural hematoma. Those are -- that makes
10 the diagnosis much clearer much earlier but,
11 unfortunately, in medicine we see a lot of
12 things that are not so obvious.

13 Q. Now, you mentioned earlier I think that you do
14 have some patients that suffer seizures. Are
15 you familiar with any patients or of any
16 situation where an individual suffered an
17 injury to their head, neck, or spine during a
18 seizure and that resulted in neurogenic
19 bladder?

20 A. I have not seen that.

21 Q. Is that possible, that someone during a
22 seizure could suffer an injury to their head,
23 neck, or spine resulting in a neurogenic

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1 bladder?

2 MS. ROSENFIELD: Objection.

3 A. I mean, it's -- of course it's possible.

4 Q. Okay. I am nearing the end of your report.

5 So the second to last paragraph you wrote a
6 sentence reading "his damages are permanent
7 and causally related to the assault of
8 September 14th, 2016." Do you see that?

9 A. Yes.

10 Q. Okay. When you say Mr. Raymond's damages are
11 permanent, are you saying that his neurogenic
12 bladder will stay with him the remainder of
13 his life?

14 A. Yes.

15 Q. Okay. And what type of difficulties, if any,
16 will Mr. Raymond incur because of the
17 neurogenic bladder?

18 A. Well, you know, he underwent major
19 reconstructive surgery that was successful.
20 Obviously there were some, you know, temporary
21 complications afterwards like a seroma and
22 then he had a hernia and all the rest of it
23 but, you know, assuming that that stuff is all

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1 behind him, you know, he will continue to
2 self-catheterize since an augmented bladder
3 doesn't contract on its own.

4 He will need to be monitored. I have
5 plenty of patients who have done augmentation
6 cystoplasty that I see typically once a year.
7 The vast majority of them do well. They don't
8 get frequent infections, and they don't have
9 trouble catheterizing. But since there is the
10 mechanical aspect of putting a catheter
11 through that abdominal stoma into the bladder,
12 you know, there is a risk of trauma. There is
13 a risk of having to have a -- you know, some
14 surgery to revise the catheterizable stoma.

15 As far as I know, I guess it's been,
16 what, over a year now. I am not aware that he
17 has had any trouble with it, but he certainly
18 needs to be monitored for UTI and for trauma.

19 I suspect kidney function will be okay though.

20 Q. And why do you say that about kidney function?

21 A. You know, as long as he is able to regularly
22 catheterize and empty his bladder, his
23 augmented bladder should be large capacity,

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1 low pressure. So even though the rest of us
2 urinate on our own and he has to catheterize
3 instead, his kidney function should be
4 preserved. So I am not -- I mean, it has to
5 be monitored but I don't expect he will have a
6 problem in that area.

7 Q. On your review of Mr. Raymond's records, do
8 you see any indication of problems with his
9 kidneys?

10 A. No. Before he underwent the surgery when he
11 had an indwelling suprapubic tube he had
12 multiple admissions for what appeared to be
13 pyelonephritis. They were somewhat confusing
14 admissions but I don't believe he has had that
15 problem now that he has a large capacity,
16 presumably low pressure bladder that's been
17 augmented.

18 Q. And upon your review of Mr. Raymond's medical
19 records, do you see any indication that his
20 condition of having a neurogenic bladder is
21 causing any detrimental issues to any other
22 parts of his body?

23 A. Not that I am aware of, other than the fact

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1 that he developed that incisional hernia with
2 all of its, you know, multiple surgeries but I
3 am hopeful that after his last abdominal wall
4 reconstruction he should be -- hopefully will
5 be okay.

6 Q. Now individuals who are in the condition that
7 Mr. Raymond is in, are they able to have sex?

8 A. They should be, yes.

9 Q. Okay. Are they able to have children?

10 A. He should be, yes.

11 Q. Okay. Are they able to work, have a job?

12 A. He should be, as long as, you know, if he --
13 the fact is if his -- again, I haven't seen
14 recent records but if his augmented bladder
15 holds the equivalent of four or five hours
16 worth of urine output, you know, he should be
17 able to go into a bathroom, catheterize
18 himself into a toilet and then go about his
19 business. So I think that that's -- you know,
20 it's a little more involved than what the rest
21 of us go through but, you know, he is
22 otherwise a young guy and should be able to do
23 that.

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1 Q. Okay. Are individuals in Mr. Raymond's
2 condition, are they able to have hard labor
3 jobs, jobs that are, you know, not necessarily
4 office related jobs but jobs that may be
5 construction or hard physical labor?

6 A. I mean, I would say as far as urologically,
7 yes. I don't want to speak in terms of
8 exactly how his abdominal wall is doing. If
9 his abdominal wall, after the other surgeries
10 he has had, if that is now fixed, then I would
11 say most likely he should be able to do that
12 but I don't know -- I don't know exactly
13 how -- you know, how his abdominal wall is
14 doing at the present.

15 Q. Okay. And people in Mr. Raymond's current
16 condition, are they able to participate in
17 physical activities, jobs, play sports, play a
18 game of basketball, things like that?

19 A. I mean, again, you know, subject to how his
20 abdominal wall is doing, the answer is yes.

21 Q. Let's take a look, this one is marked Exhibit
22 7 for today's deposition. It is a report from
23 Upstate University Health System. It looks

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1 like the date is March 7th of 2017 and it's
2 related to Mr. Raymond. Do you have that on
3 your screen, Dr. Vapnek?

4 A. Yeah, it's a little small.

5 Q. I can make it bigger for you.

6 A. Oh, you know what, I can actually get it on my
7 computer screen.

8 Q. I enlarged it, I don't know if that helps you.

9 A. Yeah, I got it. Yep.

10 Q. Okay. I am highlighting one line. It makes a
11 reference to Mr. Raymond having a past
12 surgical history that includes appendectomy
13 and hydrocelectomy. I think we talked about
14 the appendectomy earlier.

15 A. Yes.

16 Q. What's a hydrocelectomy?

17 A. Hydrocele is a fluid-filled structure that
18 surrounds the testicle and is typically --
19 it's a benign condition but that can be
20 repaired surgically.

21 Q. Okay. And when you say "benign," you're
22 referencing it to be a harmless condition?

23 A. Yeah, I mean, it can be pretty dramatic and

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1 annoying if it's the size of a melon but, you
2 know, generally once it's repaired usually you
3 go back to having a pretty normal scrotum.

4 Q. Okay. Now, having that type of procedure,
5 hydrocelectomy, could a side effect of having
6 that type of surgery be a resulting neurogenic
7 bladder?

8 A. No. The scrotum -- scrotal surgery is not
9 going to affect bladder function at all.

10 Q. Okay. We're still on Exhibit 7 so we're just
11 on the next page of Exhibit 7 which I scrolled
12 down to. I am going to highlight two lines
13 here.

14 Now there is reference to "no stricture
15 seen on cystoscopy." Do you see that?

16 A. Right.

17 Q. We talked about that earlier that it was
18 determined that he had no stricture, right?

19 A. Right.

20 Q. Okay. It does make reference "symptoms
21 possibly due to BPH or voiding dysfunction."
22 What is BPH?

23 A. BPH stands for benign prostatic hyperplasia

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1 which is a common condition of prostate
2 enlargement in the aging male, not something
3 we see in guys under 30 but obviously this was
4 a continuation of what we would call the
5 differential diagnosis now that stricture had
6 been stricken from the list by the negative
7 cystoscopy and negative VCUG that had been
8 done prior to this.

9 Q. And did you see anything in Mr. Raymond's
10 records indicating BPH?

11 A. No. You know, we could always go back and
12 look at the cystoscopy note, but usually -- I
13 shouldn't say usually. Every time we do
14 cystoscopy in a male we're putting the scope
15 through the urethra, through the prostatic
16 urethra into the bladder so we generally
17 comment on what the prostate looks like and it
18 would be extremely unusual and certainly
19 wasn't noted in this case that he had BPH.

20 Q. Let me go to Exhibit 9 of this deposition. If
21 you take a look at the document on the screen,
22 right at the bottom it's labeled as Exhibit 9.
23 It's a report from Erie County Medical Center

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1 Corporation. It looks like it has a date of
2 August 26th of 2018 and, again, it's related
3 to Matthew Raymond.

4 Going down a little bit, there is a
5 reference to the history of the present
6 illness and initial comments. Here it appears
7 that Mr. Raymond informed the medical staff
8 that the neurogenic bladder is from a 2016
9 fracture of an L4 vertebra of his back. Do
10 you see that?

11 A. Yes.

12 Q. Do you find that comment to be accurate at
13 all?

14 A. Not that I'm aware of. I don't think that
15 that was my understanding of any of the
16 imaging studies. I am not sure if somebody
17 had told him that. I don't know where that
18 comes from.

19 Q. Okay. So do you disagree that there was an
20 L4 -- a fracture of his L4 vertebra causing
21 the neurogenic bladder?

22 A. Yeah, I am not aware of that.

23 Q. Okay. L4 vertebra is kind of the lower back,

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1 correct?

2 A. Correct.

3 Q. Okay. Did you see anything in Mr. Raymond's
4 records making a reference to a fracture of
5 his L4 vertebra?

6 A. No.

7 MS. ROSENFIELD: Objection. Asked and
8 answered.

9 Q. Let's go to Exhibit 10. Exhibit 10 is another
10 document from Erie County Medical Center
11 Corporation relating to Matthew Raymond and
12 this one has a date of January 28th of 2019.

13 In this particular history Mr. Raymond
14 made reference to a spinal cord injury from a
15 motor vehicle accident 15 years ago. Would it
16 be possible that an injury 15 years ago to a
17 spinal cord could result in a neurogenic
18 bladder in 2016?

19 MS. ROSENFIELD: Objection to the form.

20 A. Highly, highly unlikely.

21 Q. Okay. Earlier you were mentioning that it is
22 possible in younger individuals that the
23 symptoms of a neurogenic bladder may not be so

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1 obvious at first and then might take some time
2 to -- for it to become obvious. Could that be
3 the case with this, that a spinal cord injury
4 from 15 years ago resulted in a neurogenic
5 bladder?

6 A. I mean, it's extremely unlikely. I mean, it's
7 essentially zero. I mean, this is so -- you
8 know, a 15-year-ago spinal cord injury and the
9 traumatic brain injury that was seven years
10 earlier, I think those are just, you know --
11 just I would say the likelihood is pretty
12 close to zero.

13 Q. Have you ever encountered something similar to
14 that, a long period like that where a patient
15 developed a neurogenic bladder years after a
16 spinal cord injury?

17 A. No.

18 Q. Scrolling down, this is Exhibit 11. Again,
19 it's related to Matthew Raymond and this has a
20 date of September 21st of 2020, and this is
21 from the Western New York Urology Associates.

22 Now in this particular document there is
23 a reference to Mr. Raymond has a history of a

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1 C2 spinal cord injury with traumatic brain
2 injury in 2016 from an assault. Do you see
3 that?

4 A. Yes.

5 Q. Okay. Now we were talking earlier about the
6 lack of any type of imaging evidencing the
7 injury that Mr. Raymond experienced. Did you
8 see any imaging in the records you reviewed
9 that show a C2 spinal cord injury?

10 A. I did not.

11 Q. Okay. Do you have any idea where this
12 reference to a C2 spinal cord injury is coming
13 from?

14 A. No, I mean, I don't. All I can say, again, in
15 a general term is that, you know, if we see a
16 patient for the first time without the --
17 without having hundreds of pages or thousands
18 of pages of old records we -- you know, we
19 take a history and, you know, sort of do the
20 best that we can. So we don't necessarily
21 know. Sometimes patients can be misinformed
22 or just confused as to what kind of conditions
23 they might have.

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1 Q. Is it all right if we take a five-minute
2 break?

3 A. You bet.

4 (A recess was taken.)

5

6 BY MR. MACKEY:

7 Q. Dr. Vapnek, one thing we didn't talk about was
8 about the van trip that Mr. Raymond had from
9 Auburn Community Hospital to the Auburn
10 Correctional Facility on September 14th, 2016.
11 In your review of Mr. Raymond's records, did
12 you see any reference to a seizure he had
13 during that particular van trip?

14 A. I don't recall.

15 Q. Okay. There are some records which make
16 reference to Mr. Raymond suffering a seizure
17 on September 14th of 2016, when he was
18 returning from the local hospital to the
19 Auburn Correctional Facility, and there is
20 statements that he suffered injuries at that
21 time. Is it possible that if he suffered
22 injuries during that particular seizure that
23 that could have caused him to injure his

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1 brain?

2 A. I mean, it's --

3 MS. ROSENFELD: Objection to the form.

4 Go ahead.

5 A. I mean, it's certainly a possibility. I think
6 it's less likely than in an assault but,
7 again, I wasn't there.

8 Q. Understood. Why do you feel less likely than
9 an assault?

10 A. I mean, just from what I have seen in this --
11 in assaults in my limited experience.

12 Q. Okay. I am sorry, maybe I misheard your
13 answer.

14 A. Just from what I -- again, it's not something
15 that we -- that urologists see on a regular
16 basis, but I have certainly, you know, had to
17 see head trauma to the point of -- you know,
18 from seizure activity. You know, major head
19 trauma is not something that -- I certainly
20 haven't seen it.

21 Q. Well, let me ask you this, obviously you have
22 a lot of patients with the condition of a
23 neurogenic bladder: Have you ever had any

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1 patients who suffered a neurogenic bladder as
2 a result of brain injury caused by being hit
3 by fists or being beaten by another human?

4 A. Yes, yeah. I mean, again, it's not super
5 common. I have one patient in particular who
6 was, from what I recall, a police officer who
7 was badly beaten and ended up retiring from
8 the force after that but he has had persistent
9 issues ever since.

10 Q. And this is a patient with a neurogenic
11 bladder?

12 A. Yeah.

13 Q. Okay. And -- well, strike that.

14 There were some photos taken of
15 Mr. Raymond later that day on September 14th,
16 2016, at the correctional facility. There is
17 a few of them of him standing up, a few of
18 them closer in to his face. Did you have a
19 chance to look at those photos during your
20 review of his records?

21 A. No.

22 Q. Okay. Now, you said that someone suffering a
23 brain injury resulting in a neurogenic bladder

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1 that it's not as common for someone to suffer
2 that if -- from a beating from another person.
3 Why do you say that?

4 MS. ROSENFIELD: Objection to the form.
5 You can answer, if you understand the
6 question.

7 A. I mean, again, just in my relatively limited
8 experience, I mean, this is certainly not a
9 large part of the practice by any means.

10 Q. Okay. Is it more common for individuals with
11 neurogenic bladder that they suffered either
12 neck, brain, or spine injury in a much more
13 forceful manner like a motor vehicle accident
14 or a fall from a high -- high place?

15 A. Those are certainly more common, certainly. I
16 mean, again, it's very -- it's always
17 difficult to predict exactly how -- you know,
18 how a brain is going to react to trauma and
19 who is going to end up with a problem and who
20 is not.

21 MR. MACKEY: I don't think I have any
22 further questions. Are you all set, Katie?

23 MS. ROSENFIELD: Yes, I am all set.

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1 Thank you so much, Dr. Vapnek. Thank you to
2 the court reporter.

3 THE WITNESS: You're welcome.

4 MR. MACKEY: Thank you, Dr. Vapnek.
5 Thank you for your time. We are all done
6 here.

7
8 (Deposition concluded at 3:54 p.m.)

9 * * * * *

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1 STATE OF NEW YORK)

2 COUNTY OF ERIE)

3

4 I, Carrie A. Fisher, Notary Public, in and
5 for the County of Erie, State of New York, do
6 hereby certify:

7 That the witness whose testimony appears
8 hereinbefore was, before the commencement of
9 their testimony, duly sworn to testify the
truth, the whole truth and nothing but the
truth; that said testimony was taken remotely
10 pursuant to notice at the time and place as
herein set forth; that said testimony was
11 taken down by me and thereafter transcribed
12 into typewriting, and I hereby certify the
foregoing testimony is a full, true and
correct transcription of my shorthand notes so
taken.

13

14 I further certify that I am neither counsel
15 for nor related to any party to said action,
nor in anyway interested in the outcome
16 thereof.

17 IN WITNESS WHEREOF, I have hereunto
18 subscribed my name and affixed my seal this
31st day of March, 2022.

19
20 

21 Carrie A. Fisher
22 Notary Public - State of New York
23 No. 01FI6240227
Qualified in Erie County
My commission expires 5/02/23

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